TESTIMONY OF

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TRINITY HEALTH OF NEW ENGLAND

SUBMITTED TO THE

INSURANCE AND REAL ESTATE COMMITTEE

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HB 5042, An Act Concerning Health Care Cost Growth

Trinity Health Of New England appreciates this opportunity to submit testimony on HB **5042, An Act Concerning Health Care Cost Growth**. We are committed to working with the legislature and Governor to ensure that this legislation leads to improving affordability and access to care.

Trinity Health Of New England includes Saint Francis Hospital and Medical Center and Mount Sinai Rehabilitation Hospital in Hartford, Saint Mary's Hospital in Waterbury, Johnson Memorial Hospital in Stafford Springs and Mercy Medical Center in Springfield, Massachusetts. In addition, our ministry includes a clinically integrated network (in partnership with Southern New England HealthCare Organization), physician practices, an ambulatory services networks, home health and post-acute services. We are more than 10,000 health care providers committed to being a healing and transforming presence in the communities we serve.

HB 5042 places in statute language implementing Governor Lamont's Executive Order No. 5 (EO 5), which requires the Office of Health Strategy (OHS) to implement, beginning in 2021, an annual cost growth benchmark, an increase in primary care spending (as a percentage of total spending), and development of quality benchmarks.

Trinity Health Of New England is committed to sustaining and improving access to high quality healthcare services across our state. We appreciate that affordability is central to that commitment and every stakeholder in the system (i.e., provider, payer, pharmaceutical and device manufacturer, employer, and government) has an important role to play in this work.

Trinity Health Of New England and health systems across the state have worked with OHS for two years on the establishment of the cost growth benchmark, primary care targets, and quality benchmarks. During this same time, we have been consumed by the response to the COVID-19 pandemic, which has had unprecedented impact on hospital and health system patient utilization, workforce availability, costs, and financial health.

The work we have done over the past two years on the Cost Growth Benchmark has been guided by a set of broad principles focused on improving access appropriate to that us affordable, and high quality. The pandemic has also taught us that strong hospitals and health systems are a key component to the response to any public health emergency.

We also developed, in collaboration with the Connecticut Hospital Association, a set of principles specific to the creation of the benchmarks and targets:

- Preserve and expand access to care
- Memorialize robust stakeholder participation and full transparency in the development of the benchmarks and subsequent periods of evaluation
- Develop spending targets that appropriately reflect and promote healthcare's important role in the state's economy
- Implement a non-punitive assessment and evaluation process
- Define the parameters by which measurement of performance against the benchmark will be determined, including what costs will be excepted
    - Excepted costs should include state spending agreements (e.g., Medicaid rate increases); exceptional circumstances (e.g., public health emergency, novel therapies, pharmaceutical price increases, financial recovery); and costs not within a provider's control
- Allow for exceptional activities (e.g., service-line expansion)
- Provide that all healthcare spending (physician, hospital, long-term care, pharmaceutical, device, payer, government, etc.) is captured in the benchmark calculation
- Include appropriate adjustment factors (e.g., risk adjustment)
- Accommodate alternative payment models (e.g., risk contracts, shared savings arrangements, etc.)
- Ensure appropriate access to and protections for data and information submitted and used for benchmark purposes

Hospitals and health systems have consistently highlighted these principles with OHS and other stakeholders.

We also believe there must be an understanding and consideration of the costs associated with providing care, including the significant impact inflation is having and will have into the future, the overwhelming labor costs that have increased significantly over the last year, pharmaceutical costs, and the continuing effects of COVID-19 on resource utilization and care delivered outside the four walls of the hospital, such as vaccination and testing.

We also note concerns raised about potential effects on access to care and believe those concerns need to be front of mind as we continue with this process. We must not allow benchmark implementation to result in diminished access for patients to healthcare providers and services.

We appreciate the opportunity to share these principles and our ideas with the Committee. Consistent with these principles, we suggest the Committee consider amendments in the following areas:

Require Reauthorization

The legislation should authorize the benchmarks and targets through 2025 and require their reauthorization by the legislature for implementation beyond that date.

As we continue the work of implementing the benchmarks and targets, we should acknowledge that we cannot be fully aware of the impacts of their implementation. We do not know yet their full effect on patient access, care innovation, care delivery, and care and service-line expansion.

It is also too early to identify how the pandemic will affect the future of healthcare delivery in our state. There is no analogue for attempting to implement a statewide healthcare spending target during a global pandemic.

The legislature should acknowledge the potential promise of benchmark implementation, while being thoughtful in planning that implementation.

Benchmark Development and Evaluation

In addition to the factors outlined in the legislation, OHS should also be required to consider other factors such as the adequacy of public payer (i.e., Medicare and Medicaid) provider reimbursement rates, labor costs, medical inflation, costs of breakthrough treatments and medical advances, and the impact of the COVID-19 pandemic and future public health emergencies when setting the benchmark values.

Public Process for Evaluating Benchmark Values

The Office of Health Strategy should be required to hold a public hearing on the benchmark values and report publicly on why such values are either maintained or changed after the hearing.

Public Reports

In addition to the requirements outlined in the legislation, the required annual report by OHS should also include information on payer and provider input costs, including pharmaceutical costs, the adequacy of Medicare and Medicaid payment rates as they relate to the cost of care, the impact of the rate of inflation and rate of medical inflation, impacts on access to care, medical service expansion, and pursuit of medical innovation, the effect of patient acuity, and any impact on the response to a public health crisis.

Analyzing Benchmark Attainment

The legislation should be amended to clarify that a payer or provider that is found to have not met the benchmark target should have the opportunity to meet directly with the OHS to review the factual basis for findings on noncompliance, provide information to dispute or contextualize such finding, and request that the executive director amend the finding. The names of payers and providers subject to this process should remain confidential. Public reporting on attainment of the benchmark should also be done at the state, market, and provider type levels.

Thank you for your consideration of our position. For additional information, please contact me at dkeenan@trinity-health.org or 860-714-0437.